



COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities (LTCFs)

Since COVID-19 is now circulating in communities across Colorado, all LTCFs should implement additional measures to prevent COVID-19 from entering the facility. **Prevention** measures should be implemented immediately to protect residents from possible COVID-19 infection. **Rapid Response** measures should be implemented immediately when even a single case of respiratory illness is identified in a resident. This checklist is updated regularly and guidance is subject to change.

I. Prevention

Every LTCF should immediately implement the following:

Restrictions for Visitors and Non-Essential Healthcare Personnel

- Post signage at the front entrance restricting visitors and non-essential staff.
- Restrict all volunteers and non-essential healthcare personnel from entering the facility.
- Restrict all visitation except for certain compassionate care situations, such as end of life situations. (See Public Health Order 20-20.)
 - All essential visitors must be actively screened when entering the building, to include fever, any respiratory symptoms or other symptoms of infection, and potential exposure to COVID-19.
 - All visitors should sign-in, including: name of visitor, resident that was visited, date of visit and time.
 - Visitors should perform hand hygiene and wear a facemask/face covering when entering the building.
 - Visitors should be limited to 2 persons at a time for a resident.

Monitor Staff and Residents for Fever and Symptoms of Respiratory Infection

- All staff should be actively screened at the beginning of their shift for fever (take temperature) and symptoms (cough, shortness of breath, difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory [smell] and taste disorder(s); consider also rhinorrhea, diarrhea, nausea or vomiting).
- Any staff member with identified illness (as defined above) should immediately use a facemask, cloth face covering, or a tissue for source control and leave the facility. They should be excluded from work based on return-to-work criteria.¹
- Active monitoring of all residents should occur once daily to include temperature, heart rate, blood pressure, respiratory rate, pulse oximetry, changes in mental status, and any symptoms (cough, shortness of breath, difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory [smell] and taste disorder(s); consider also rhinorrhea, diarrhea, nausea or vomiting).
- Reinforce sick leave policies. Remind staff not to report to work when ill with even mild symptoms.

Social Distancing

- Restrict all residents to their rooms as much as possible, making sure residents remain safe and considering resident well-being and mental health. Try to keep residents within a unit, wing or floor when possible.
- If residents must leave their room, they should perform hand hygiene, limit their movement within the facility, wear a face mask or cloth face covering, and perform social distancing (stay at least 6 feet from others).
- All group activities should be cancelled.
- Communal dining should be cancelled unless assistance is required as part of the resident care plan. Residents requiring assistance with feeding should maintain a 6-foot distance from other residents during supervised meals and staff should perform hand hygiene when moving from one resident to another. (This applies to residents that do not have symptoms or diagnosed COVID-19.)



Isolation Precautions

- Implement universal use of facemasks for all facility staff. Strongly consider extended use of facemasks when PPE supply in the community is limited.² Staff that do not come in contact with residents (e.g., clerical personnel) might wear a cloth face covering for source control while in the healthcare facility.
- Staff working in facilities located in areas with moderate to substantial community transmission (e.g., Stay-at-Home or Safer-at-Home public health orders) should wear eye protection in addition to their facemask during patient care encounters.
- Limit staff movement; cohort staff to a unit when possible, including across multiple shifts.
- Discourage staff from working in multiple facilities, when possible.
- Standard precautions should always be followed.
- Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of PPE. Have healthcare staff demonstrate competency with putting on and removing PPE.
- Residents who must regularly leave the facility for care (e.g., hemodialysis) should wear facemasks or cloth face coverings when outside of their rooms including when outside of the facility.
- When possible, all long-term care facility residents, whether they have COVID-19 symptoms or not, should cover their noses and mouths when staff are in their room. Residents can use tissues for this. They could also use cloth, non-medical masks when those are available. Residents should not use medical facemasks unless they are COVID-19-positive or assumed to be COVID-19-positive.
- Residents admitted or readmitted to the facility should be placed under observation for 14 days with transmission-based precautions. This does not apply to residents leaving the facility for outpatient care (e.g., hemodialysis).
- Even when there are no residents in the facility that require isolation for COVID-19 infection, facilities should maintain a COVID-19-positive neighborhood, and not admit residents to that neighborhood. This will allow facilities to rapidly move residents when COVID-19 is identified. Designating and maintaining a COVID-19-positive neighborhood ahead of time will also prevent shuffling of residents between rooms and neighborhoods during an outbreak and avoid additional spread of infection in the facility.

Communicate with Staff, Residents and Families

- Educate residents and families, including
 - Information about COVID-19
 - Actions the facility is taking to protect them and their loved ones, including visitor restrictions and how they can protect themselves.
 - Implement strategies that allow residents to communicate with family/friends while following the above recommendations (e.g. video chats using technology) to prevent the transmission of COVID-19 within the facility.

Supplies

- Ensure adequate hand hygiene supplies: Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., in dining room at front entrance). Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Make necessary PPE available in areas where resident care is provided.
- Put a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room, or before providing care for another resident in the same room.
- Ensure adequate supplies for respiratory hygiene and cough etiquette.



- Make tissues and cloth face coverings (or facemasks) available for coughing people. (Prioritize facemasks for healthcare personnel.)
- Consider designating staff to steward those supplies and encourage appropriate use by residents, visitors and staff.

Assess current facility inventory of PPE. Facilities should have a two-week supply of:

- facemasks
- respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested providers)
- gowns
- gloves
- eye protection (i.e., face shield or goggles)

Ensure adequate supplies and procedures for environmental cleaning and disinfection.

Environmental Cleaning and Disinfection

- Ensure that all non-dedicated, non-disposable resident care equipment (e.g., thermometers, pulse ox, blood pressure cuffs, resident lifts) is cleaned and disinfected according to manufacturer's instructions after each use, prior to use on additional residents.
- Use an EPA-registered, hospital-grade disinfectant to frequently clean high-touch surfaces and shared resident care equipment in addition to routine environmental cleaning. Refer to the EPA website for a complete list of approved disinfectants with an emerging viral pathogen claim:
<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>.
- Validate environmental services staff members processes: (1) Follow label instructions on the hospital grade disinfectant; (2) Validate disinfection policies and procedures (e.g., cleaning from clean to dirty, changing gloves and performing hand hygiene between rooms and between resident surfaces within the same room).



II. Rapid Response

Additional measures to be implemented when suspected illness (fever or respiratory symptoms) is identified in even a single resident:

Restrict New Admissions

- If you have one or more residents with fever or respiratory symptoms, in collaboration with public health, consider halting new admissions until an outbreak of COVID-19 has been ruled out and/or the outbreak is contained (14 days after the date of symptom onset of the last known case in residents or staff). Residents can be readmitted back to the same facility. (Under certain circumstances, new admissions might be considered in consultation with public health). When admissions resume, residents admitted or readmitted to the facility should be placed under observation for 14 days with transmission-based precautions.

Monitor Staff and Residents for Fever and Symptoms of Respiratory Infection

- Increase active monitoring of all residents to two times daily to include temperature, heart rate, blood pressure, respiratory rate, pulse oximetry, changes in mental status, and any symptoms (cough, shortness of breath, difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory [smell] and taste disorder(s); consider also rhinorrhea, diarrhea, nausea or vomiting). Ill residents should be monitored at least three times daily.

Social Distancing

- Restrict all residents to their rooms with the door shut to the extent possible, ensuring resident safety, well-being and mental health.
- If residents with fever or respiratory symptoms must leave their room, they should perform hand hygiene, limit their movement within the facility, perform social distancing (stay at least 6 feet from others), and should also wear a facemask, wear a cloth face covering, or use tissues for source control. Prioritize facemasks for healthcare personnel.
- Communal dining should be cancelled unless assistance is required as part of the resident care plan. Residents requiring assistance with feeding should maintain a 6-foot distance from other residents during supervised meals and staff should perform hand hygiene when moving from one resident to another. (This applies to residents that do not have symptoms or diagnosed COVID-19.)

Isolation Precautions

- Restrict staff movement between areas of the facility with and without ill residents (which might be accomplished by cohorting staff to a unit across multiple shifts). Staff as much as possible should not work across units or floors. Facilities should also use separate staffing teams for COVID-19-positive residents to the best of their ability. The goal is to decrease the number of different staff interacting with each resident as well as the number of times those staff interact with the resident.
- Staff should follow standard, contact and droplet precautions (with eye protection) for any resident with fever, respiratory symptoms, or when COVID-19 is suspected.^{2,3,4}
- When discordant roommate pairs are identified (e.g., one roommate is positive for COVID-19 and the status of the other roommate is unknown or negative), it is preferable to separate roommates. Options include moving the roommate who is COVID-19-positive to a designated COVID-19 care unit (housing ONLY COVID-19-positive residents) or to a private room in the same wing or hallway. Refer also to Long-term Care Cohorting Recommendations - Residents With Respiratory Illness & COVID-19 Infections: <https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html>. Other options should be discussed with public health prior to moving residents.



- Avoid transferring residents between different units. When designating separate units or facilities to care for COVID-19-positive residents and COVID-19-negative residents, it is recommended to consult with public health prior to moving residents.
- When EMS is activated, notify them that the facility is currently experiencing a suspected or confirmed outbreak of COVID-19 prior to their arrival so they may don appropriate PPE prior to resident contact. All recommended PPE should be worn for care of any resident requiring CPR or other emergent procedure.
- If transfer is medically indicated, inform the receiving facility that the facility is currently experiencing a suspected or confirmed outbreak of COVID-19 verbally in addition to written documentation prior to the arrival of the resident at the receiving facility.
- All visitors that must enter the facility (e.g., compassionate care) must wear appropriate PPE if visiting a resident with suspected or confirmed COVID-19 (e.g., gloves, gown, facemask and eye protection). In times of PPE shortages, prioritize a facemask.

Testing

- When one or more residents are identified with fever or respiratory symptoms, collect specimens on symptomatic residents as early as possible in the course of illness to test for COVID-19. Residents should also be assessed for other etiologies (e.g. influenza, RSV, etc.) according to clinical suspicion and considering local circulation of respiratory viruses.
- Consider post-mortem testing on residents who die of respiratory illness or die unexpectedly when a suspected or confirmed COVID-19 outbreak is ongoing.
- When a suspected or confirmed outbreak is identified, test all residents and staff. Consult public health for testing assistance.

Environmental Cleaning and Disinfection

- Limit shared medical equipment: dedicate equipment for residents with respiratory illness or elevated temperature when possible. Medical equipment should not be shared between a designated COVID-19 care unit and other units in the facility.

Communication

- Communicate with staff, residents, and families about the suspected or confirmed COVID-19 outbreak, and steps the facility is taking to halt the outbreak. Confirmed outbreaks will be publicly reported by facility name by the state emergency operations center.

Notify Public Health Immediately

- If you have a single suspected or confirmed case of COVID-19, or a suspected or confirmed outbreak of COVID-19, report to public health immediately. (See Case and Outbreak Definitions: <https://www.cdc.gov/coronavirus/2019-ncov/lab/guidelines-clinical-specimens.html>)



Footnotes

¹ Return-to-work criteria for healthcare personnel with suspected or confirmed COVID-19

- *HCP with mild to moderate illness who are not severely immunocompromised:*
 - *At least 10 days have passed since symptoms first appeared and*
 - *At least 24 hours have passed since last fever without the use of fever-reducing medications and*
 - *Symptoms (e.g., cough, shortness of breath) have improved*
 - *Note: HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.*
- *HCP with severe to critical illness or who are severely immunocompromised:*
 - *At least 20 days have passed since symptoms first appeared*
 - *At least 24 hours have passed since last fever without the use of fever-reducing medications and*
 - *Symptoms (e.g., cough, shortness of breath) have improved*
 - *Note: HCP who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.*
- *For more information, see [Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection \(Interim Guidance\)](#)*

² PPE-sparing strategies:

- See CDC PPE-sparing strategies for more information (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>).
- CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. Contingency strategies can help stretch PPE supplies when shortages are anticipated, for example if facilities have sufficient supplies now but are likely to run out soon. Crisis strategies can be considered during severe PPE shortages and should be used with the contingency options to help stretch available supplies for the most critical needs. As PPE availability returns to normal, healthcare facilities should promptly resume standard practices.
- CDC: Using Personal Protective Equipment <https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>
- Sequence for proper donning and doffing of PPE: <https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf>.

³ CDC and CMS recommend that if COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE (gowns, gloves, facemask and eye protection) for the care of all residents irrespective of COVID-19 diagnosis or symptoms. When PPE shortages are present, this recommendation may be impractical for implementation by healthcare facilities, and PPE use should be prioritized for use with any resident with fever, respiratory symptoms, or when COVID-19 is suspected.

⁴ Discontinuation of Isolation for Residents:

- *Residents with mild to moderate illness who are not severely immunocompromised:*
 - *At least 10 days have passed since symptoms first appeared and*
 - *At least 24 hours have passed since last fever without the use of fever-reducing medications and*
 - *Symptoms (e.g., cough, shortness of breath) have improved*
 - *Note: For residents who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.*
- *Residents with severe to critical illness or who are severely immunocompromised:*
 - *At least 20 days have passed since symptoms first appeared and*
 - *At least 24 hours have passed since last fever without the use of fever-reducing medications and*
 - *Symptoms (e.g., cough, shortness of breath) have improved*

